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How Will the Charter of Rights and Freedoms and Evolving Jurisprudence Affect Health Care Costs?

by

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Highlights

- The *Charter of Rights and Freedoms* covers governments' policies about health care.
- Only a handful of *Charter* actions have challenged health care policies. About one-third of actions have been successful – eleven in total.
- People have used section 7 to challenge policies about the structure of health care, such as methods of allocating billing numbers and restrictions on private health insurance. Except for British Columbia cases involving allocation of doctors' billing numbers, the challenges have failed.
- People have used section 15 to challenge policies about the scope of coverage for insured medical services. The courts have upheld only two such claims.
- Doctors in British Columbia in the 1980s and 1990s successfully relied on section 6, as well as section 7, to challenge policies about billing numbers. However, this case law is now discredited, and recently a challenge to a similar policy in New Brunswick failed.
- Section 1 permits governments to justify violations as reasonable limits. Generally, courts have been sensitive to the governments' need to manage health care resources effectively, and have given governments a margin of appreciation in selecting policies. Section 1 balancing may also occur within sections 7 or 15.
- The right to health is firmly embedded in international law. It includes the right of access to health care services, and may evolve to include a broader right to health. In international law, State Parties have an obligation to take positive measures to ensure enjoyment of these rights. Since international law influences the interpretation of the *Charter*, this evolution will affect *Charter* rights.
- To date, the impact of *Charter* actions on health care costs, with the exception of the billing number cases, has not been great. The *Canada Health Act* principles of universality, comprehensiveness, and accessibility implement *Charter* values of equality and dignity.
- However, governments can expect more *Charter* litigation. They may minimize the risk of judicial disruption of health care policies by taking *Charter* values into account and justifying their decisions with the best available evidence.

Executive Summary

The *Charter of Rights and Freedoms* covers governments' policies about health care. The *Charter* may be used as a shield by patients and providers who wish to protect aspects of the current system from change. At the same time, the *Charter* may be used as a sword by patients and providers who object to reform proposals or the status quo. Since the *Charter*'s enactment in 1982, only a small number of *Charter* actions have challenged health care policies. Appendix II briefly describes the 33 salient cases. Only 11 actions have succeeded. Their impact on health care costs has been uneven, but not great overall.

Specific *Charter* Provisions

Three *Charter* rights have the most relevance to the health care system: section 15 (equality rights), section 7 (life, liberty and security of the person), and section 6 (mobility rights).

Section 15

Section 15 guarantees the right to the equal benefit of the law without discrimination on the basis of enumerated grounds (such as disability) or analogous grounds. It has been used to challenge governments' decisions about the scope of coverage for insured medical services. Courts have upheld these claims in only two cases: *Eldridge* and *Auton.* In *Auton* the court ordered the government to pay for health services, thereby expanding the scope of coverage. In *Eldridge*, however, the plaintiffs were not asking to add an uninsured service to the list of insured ones but for the government to pay for sign language interpretation that would permit them to access services available to everyone.

Section 7

Section 7 protects the right not to be deprived of life, liberty and security of the person except in accordance with the principles of fundamental justice. Courts have generally held that liberty does not include economic liberty, but it may protect economic matters that pertain to health care. Security of the person includes freedom to choose medical treatment without fear of criminal sanction.

Courts have struck down criminal laws that prohibit or unduly restrict medical treatment as violations of section 7 (*R.* v. *Morgentaler*; *R.* v. *Parker*). However, these cases are rare, and have little impact on health care costs.

Section 7 has also been used to challenge policies about the structure of health care, such as methods of allocating billing numbers and restrictions on private health insurance. With the exception of cases from British Columbia involving allocation of doctors' billing numbers, these

challenges have failed. However, if more of these cases were successful, they would have serious ramifications for health care costs.

Section 6

Section 6 guarantees the right to take up residence and earn a livelihood in any province. Doctors in British Columbia in the 1980s and 1990s successfully relied on section 6, as well as section 7, to challenge policies about billing numbers that sought to restrict new doctors to under-serviced areas of the province. However, this case law is now discredited, and recently a challenge to a similar policy in New Brunswick failed.

Section 1

Section 1 permits governments to justify violations as reasonable limits. Generally, the courts have been sensitive to the governments' need to manage health care resources effectively, and have given governments a margin of appreciation in selecting policies. Sometimes the section 1 balancing occurs within section 7 or section 15.

Under section 1, governments must adduce evidence to prove the reasonableness of their health care policies. This obligation may promote evidence-based health care.

International Law

The scope of *Charter* rights is influenced by international law. Canada is a signatory to many international conventions, such as the *International Covenant on Economic, Social and Cultural Rights*, that expressly include rights to health.

The right to health is firmly embedded in international law. It includes the right of access to health care services, and may evolve to include a broader right to health. In international law, State Parties have an obligation to take positive measures to ensure enjoyment of these rights. They cannot avoid their obligations to promote access to health care services by privatizing health care.

Canadian courts take into account international law in interpreting the *Charter*. Accordingly, the evolution of international law will affect *Charter* rights. If social rights, such as health care, gain more priority within international law, Canadian courts will likely be more willing to interpret *Charter* rights in a manner that imposes more positive obligations on governments.

Future Developments

To date, the impact of *Charter* actions on health care costs, with the exception of the billing number cases, has not been huge. One reason for the small number of successful challenges is judicial sensitivity to the complexities of the health care system. Moreover, principles of the existing Medicare system – universality, accessibility and comprehensiveness – reflect *Charter* values of equality and human dignity.

The potential for litigation is an inescapable component of the health care system. Governments cannot avoid completely the *Charter* by privatizing health care services or by using the section 33 override. They can reduce the risk of judicial disruption of health care policies by explicitly taking *Charter* values into account in their health care policies, and justifying their decisions with the best available evidence.

I. Introduction

The *Charter of Rights and Freedoms*, as part of the Canadian Constitution, regulates governments' decisions about health care services. The *Charter* does not expressly guarantee either a right to health or a right of access to health care. However, its general rights provisions, such as equality rights, cover many aspects of the health care system. Since the *Charter*'s enactment in 1982, persons have brought court actions that use *Charter* rights to challenge health care policies.

To date, the number of *Charter* challenges to facets of the health care system is not large, and the majority of them have been unsuccessful. Their impact has been uneven. The most successful litigants have been doctors, who have mobilized *Charter* rights to prevent governmental policies that affected their remuneration and mobility. The least successful plaintiffs have been groups and individuals opposing hospital restructuring, with no victories grounded directly in the *Charter*. Patients have been only slightly more successful at using the *Charter* in their efforts to obtain particular health services at public expense. However, notwithstanding the small number of successful challenges since 1982, *Charter* litigation has the potential to affect significantly the allocation of health care resources, both the distribution of public money within the current Medicare system and the boundaries between the public and private components of health care. Consequently, health care reform needs to take into account the imperatives of *Charter* rights.

Part II describes the *Charter's* application in the health care field. It focuses on the *Charter* rights with most relevance for health care decisions, summarizing briefly the jurisprudence under sections 7, 15, and to a lesser extent, section 6. Part III examines in closer detail the jurisprudence under section 1 of the *Charter*, and Part IV discusses the relevance of international jurisprudence. Part V gives an overall analysis of the *Charter*'s potential impact on health care costs.

II. The *Charter* and Health Care Policies

A. General

Because the *Charter* is an entrenched legal document, people may launch legal actions to change governmental decisions that they believe interfere with their rights. Indeed, people do not bring *Charter* actions for any reason other than to change governmental decisions. Every time a plaintiff succeeds with a *Charter* action, governmental decisions are modified or reversed. Since almost all governmental decisions involve expenditures, a successful court action means that money will be spent in ways different from those that governments had first wanted. Governments faced with a court order that requires expenditures have a number of options with respect to covering the cost. They include the following: divert the money from other components of the health care system; manage the existing system more efficiently and use the savings to cover the costs of the court order; divert more money into the general health care budget from other areas of spending; offload some costs to users; decrease the money paid to providers; raise taxes; or a combination of these and other methods. Regardless of the method it chooses to cover the cost of a remedy, the government's spending decisions are affected. Indeed, the only way that the *Charter* could not affect government spending in some way is if no plaintiffs ever win their lawsuits.

The *Charter's* application to health care policies brings into play several other general features of *Charter* litigation. First, as with other areas of public policy, the *Charter* shifts a measure of power over health care reform to judges. They assess the merits of *Charter* claims and determine whether an aspect of the health care system complies with *Charter* rights. If it does not, they order governments to change the particular rule or practice. When governments first introduced Medicare, beginning with Saskatchewan's legislation in 1962, judicial involvement in the program's design and implementation was minimal. The *Canada Health Act*, sometimes considered the bedrock of Medicare, did not need to consider *Charter* litigation when it was enacted in 1984, as the *Charter* had come into force a mere two years earlier. Now, however, reform initiatives must take into account judicial interpretations of *Charter* rights, and be defensible in a courtroom, not only an operating theatre. Generally, the availability of judicial review based on entrenched rights narrows the range of policy options available to governments (Manfredi and Maioni 2002, 217-219).

Second, the *Charter* has a homogenizing effect. Since constitutional rights apply across the country, an interpretation by one court will influence other judges and policymakers. Decisions from the Supreme Court of Canada are binding on lower courts, and decisions from provincial appellate courts have persuasive authority. This inescapable feature of *Charter* adjudication has consequences for health care costs. For instance, a ruling by a court in one province that the province must pay for a particular service means that other provinces will likely have to pay, too. A ruling that a specific reform, such as changing methods of paying doctors, is off limits to one province likely means that no province can introduce it. This tendency toward uniformity reduces sensitivity to local conditions (Manfredi and Maioni 2002, 219-221), and could dampen the increasing diversity in provincial reform initiatives (Gray 1998, 928).

Third, the *Charter* offers people additional arguments in political debates about health care policies. Because of the *Charter*, the discourse of rights is an increasingly important component of public policy formation. Even if people do not intend to launch legal actions to vindicate rights, they may resist controversial changes to health care services as encroachments upon their rights. Or, they may use rights language not as a shield to protect the existing system but as a sword to pressure governments into facilitating changes that they prefer, such as permitting private health insurance or adding particular treatments to the list of insured services. In the same way, governments may be able to justify reforms, or the status quo, as enhancing *Charter* rights. To the extent that deployment of rights language in political debates succeeds in influencing policy outcomes, the *Charter* has an impact upon costs, although in a more intangible and non-quantifiable way than with court actions.

Many features of the health care system are subject to *Charter* claims.

1. The *Charter* may restrict a government's options for payment and supply of medical services. For instance, doctors in British Columbia successfully argued that their section 7 liberty rights and section 6 mobility rights were infringed by policies allocating billing numbers (*Re Mia* 1985; *Wilson* 1988; *Waldman* 1999). However, the Supreme Court has rejected the interpretations that succeeded in *Re Mia* and *Wilson*, and the New Brunswick Court of Appeal recently rejected a section 6 challenge to a similar billing number policy in that province (*Rombaut* 2001).

2. People have used *Charter* arguments to challenge integral aspects of the Medicare system, such as the prohibition on private health insurance, but thus far unsuccessfully (*Chaoulli* 2002).

3. The *Charter* affects governments' decisions about particular services to include within publicly funded Medicare systems. These decisions may violate section 15 equality rights (*Eldridge* 1997; *Auton* 2000). If courts order governments to pay for these previously uninsured services, they expand the scope of publicly funded services, shifting the balance between public and private funding.

4. The right of parents to choose or refuse medical treatment for their children may be an aspect of their right to liberty in section 7, and, if they decide on religious grounds, their freedom of religion in section 2(a) (*R.B.* v. *Children's Aid Society* 1995).

5. The involuntary treatment of persons with mental illnesses is subject to section 7 rights of liberty and security of the person (Carver 2002).

6. The *Charter* is implicated in the "right to die with dignity" cases, in which patients assert constitutional rights to choose the manner and time of their deaths (*Rodriquez* 1993).

7. The *Charter* affects the governments' prohibition of particular health services. In *R.* v. *Morgentaler* (1988), the Supreme Court's first involvement with the *Charter*

and health care, the Court struck down the Criminal Code restrictions on abortion services as a violation of a woman's right to security of the person.

8. The *Charter* covers the employment relationship between governments and health care workers. However, not every work relationship in a health care facility falls within the *Charter*'s purview (*Stoffman* 1990).

9. The *Charter* affects the legal power of professional organizations in the health care sector to regulate the activities of their members. The courts have struck down bans on advertising by dentists as a violation of freedom of expression (*Rocket* 1990) and a bylaw preventing optometrists from having business associations with other optometrists (*Costco Wholesale* 1998).

Each type of litigation has an impact on costs. For instance, even those decisions that reduce procedural complexities of accessing services, such as *Morgentaler*, will affect costs in several ways. For one thing, complying with procedures always has direct and indirect costs, and changing procedures will alter these costs. In addition, since procedural obstacles often have a deterrent effect, simplifying procedures may increase total cost because more people will obtain the service. However, the most important effects of the *Charter* on health care costs result from cases in the first three areas. These areas comprise two related categories: structure of payment and delivery of health care, and scope of coverage with respect to publicly insured services (Von Tigerstrom 2002).

The first category involves changes to the methods by which governments pay for health services and provide them. Generally, Canada has a mixed system, with considerable public financing and mostly private delivery. Whether and how to change the mix between the public and private components of health care financing and delivery is one of the key policy questions of our time. *Charter* rights may be invoked to question the wisdom and constitutionality of proposals that alter the mix or restructure in other ways the institutions of health care. This category includes challenges by doctors to changes in physician management schemes (e.g., *Rombaut* 2001), attempts to enjoin hospital closures (e.g., *Wellesley Central Hospital* 1997; *Ponteix* 1994), and actions to permit private health insurance for services covered by Medicare (*Chaoulli* 2002). The last type of action, if successful, has the potential for causing the most dramatic change to the health care system, since removing the ban on private health insurance would create a two-tier or multi-tiered system (Schrecker 1998, 143).

The second, related category involves challenges by patients who want the government to pay for more services than those currently covered by the medical insurance plan (e.g., *Cameron* 1999*a*; *Auton* 2000). Here, again, successful court actions change the mix between public and private funding. These lawsuits usually do not strike at the core of Medicare's principles. Rather, because they ask for public insurance to include more services, they seek expansion of the principles of universality and accessibility. However, that does not reduce their potential to affect significantly the distribution of health care costs.

Overall, *Charter* actions brought by patients and others have been few in number. Appendix II lists *Charter* decisions that involve, in some aspect or another, health care services, whether provided in hospitals, clinics, nursing homes or schools. (The table excludes cases involving involuntary treatment of patients, fetal rights, and informed consent.) There are only 33. Even if this number were doubled to compensate for any cases missed by the searches, the total number would not be large. This low number is surprising. Since health care affects everyone and is the largest single budget item for provinces, one would expect more litigation, especially in light of the state of flux in the health care system.

With these 33 cases, claimants in 11 cases succeeded in obtaining remedies for a *Charter* violation. The rate of success, 33 percent, is in line with the general success rate for *Charter* claims from 1982-98, which most authors calculate at between 30-35 percent (Kelly 1999). Moreover, in several cases in which plaintiffs have successfully proven a violation of a *Charter* right, the government has demonstrated that the violation is a reasonable limit under section 1 (*Cameron* 1999*a*). Courts have been cautious about judging governments' health care policies as unreasonable. Further, in several *Charter* actions where plaintiffs obtained remedies, governments did not attempt to raise section 1 arguments (*Re Mia* 1985; *Wilson* 1988). If they had, the results might have been different, and the number of successful challenges even lower.

The impact of these successful cases on health care costs is difficult to assess because no numbers are readily available. Nevertheless, it is possible to draw tentative conclusions. Overall, of the 11 cases in which courts gave a remedy, the ones with the greatest impact on health care costs were the doctors' mobility and liberty claims. The provinces' restricted ability to ration physician services likely had financial ramifications in the tens or hundreds of millions of dollars, not only in British Columbia, where the cases originated, but also in other provinces that were considering similar schemes in the late 1980s and early 1990s. At the other end of the cost spectrum, several successful cases likely had a much smaller effect on overall costs: *R.* v. *Morgentaler* (1988), which involved access to abortion services; and *R.* v. *Parker* (2000), which concerned access to marijuana for medical purposes. Somewhere in between are cases such as *Lalonde* (2001). *Lalonde* is similar to the doctors' mobility rights cases because it involves structural issues of health care delivery. On its face it involves a large sum of money because the Ontario government decided not to proceed immediately with restructuring services at the hospital in dispute. However, more precise information is needed to assess the monetary consequences of a failed attempt at hospital restructuring. Whether closure of a particular hospital saves money in the long run depends on several factors, such as the inefficiency of the hospital in question, and whether services are managed efficiently among other hospitals in the area.

With respect to challenges about the scope of insured services, patients obtained remedies in only two cases. In *Eldridge*, the Supreme Court accepted evidence that the cost of providing sign language interpreters was $150,000, which was approximately 0.0025 percent of the provincial health care budget. Since all provinces now have to provide such a service, the nationwide cost is greater (assuming that some provinces did not provide the service before the court decision), but still not significant. In *Auton*, the British Columbia court ordered Lovaas treatment for autistic children, which was estimated to cost $40,000 to $60,000 a year per child, with treatment

ranging from two to five years per child. Unfortunately, the court did not estimate the total cost of the service. Although several provinces already pay for this treatment when recommended by doctors, others do not. On a national basis, the cost implications of this ruling would not be negligible.

Overall, the direct effect of *Charter* litigation on health care costs has not been large, except with respect to restructuring physician services. However, the future may be quite different. One scholar's comment about the Supreme Court is apt: "Offering predictions about the Court's future use of the *Charter* is a dangerous game" (Kelly 1999, 636). Kelly concludes that the Supreme Court's recent decisions indicate a trend toward minimizing conflict with the legislative branch (636), which would suggest that governments may not need fear too greatly an activist judiciary. On the other hand, studies also show that judges are more inclined to nullify recent policy choices by provincial legislatures (Manfredi and Maioni 2002, 221), which would mean that new provincial policy directions in the health care field are more susceptible to judicial reversal.

In grappling with the question of future judicial involvement, this paper focuses on the courts' interpretation of the most important *Charter* rights. On the premise that courts rarely change jurisprudential direction overnight, the interpretations accepted to date for *Charter* rights would continue to structure arguments in the near future.

Appendix I reproduces the most relevant *Charter* provisions. Section 15, the equality rights provision, gives everyone the right to equality without discrimination on a number of grounds. Two of the enumerated grounds have direct relevance to the health care field – physical and mental disability. Section 7 gives everyone the right not to be deprived of life, liberty and security of the person, except in accordance with the principles of fundamental justice. Section 6 states that every citizen and permanent resident has the right to pursue the gaining of a livelihood in any province. If a court rules that a person's rights have been violated, governments may justify the limitation under section 1 as reasonable in a free and democratic society. However, justificatory arguments also come into play in interpreting the scope of rights.

B. Section 15

Claims under section 15 have focused on expanding the scope of insured services. Persons allege that a particular health care policy, which excludes them from coverage or reduces their share of resources, violates their rights to the equal protection and equal benefit of the law. The potential for claims is theoretically quite broad because one prohibited ground in section 15 is physical or mental disability. Although the courts have not issued an authoritative definition of this ground, it covers illnesses and a wide array of conditions. However, the total number of *Charter* claims under section 15 is very small, and only two, *Eldridge* and *Auton*, have been successful. Courts have been cautious about ordering governments to pay for particular health services.

This conclusion may seem surprising in light of the considerable media attention given to the Supreme Court's unanimous judgment in *Eldridge*. A group of deaf patients argued that the British Columbia government's decision not to fund sign language interpreters for them when they received medical treatment violated their right to equality under section 15. Specifically, they argued that this failure constituted adverse effects discrimination on the basis of physical disability because their inability to communicate effectively with medical personnel denied them the equal benefit of the provincial Medicare program. The Supreme Court agreed and directed the government to provide sign language interpreters where necessary for effective communication.

The *Eldridge* ruling imposes a positive obligation on governments to provide a particular service for patients. However, it does not open the floodgates to constitutional challenges about the scope of "insured medical services." As the Court stressed in its reasons, the inequality was about *access* to insured health care services. The plaintiffs were not asking for a specific medical treatment that the government had decided not to fund, such as expensive fertility treatments. Rather, they wanted equal access to all the services, and no more than those services that were available to the hearing population. The problem was not the services offered by the government but the fact that the government provided the services in a manner that hearing persons could readily access, but not deaf people. As in the earlier *J.C.* (1992) decision from a lower court about the exclusion of women from prisoners' treatment programs, the *Eldridge* claimants could not access equally services that were generally available to others because of an enumerated ground (disability in *Eldridge*; sex in *J.C.*).

The policy that distressed the patients in *Eldridge* is an example of "rationing by characteristic" – a particular health care service is insured, but not everyone who can benefit from the service can access it. Governments also engage in "rationing by service" – a specific medical treatment for a particular illness or condition is not funded for anyone. For example, in *Cameron* the province funded some hospital services for infertility, but not *in vitro* fertilization (IVF) or intra-cytomplasmic sperm injection (ICSI). In *Auton*, the province funded some treatment for autistic children, but not the Lovaas treatment preferred by the plaintiffs, who were parents of autistic children. These cases, which involve the scope of coverage, raise different questions. Governments assess a broad range of factors in making such decisions, including the cost of the treatment, its effectiveness in improving the patient's quality or length of life, and social and ethical concerns. Moreover, courts may hesitate to evaluate complex decisions about the clinical effectiveness and other medical standards for highly specialized treatments (Von Tigerstrom 2002, 171). Von Tigerstrom argues that cases involving "rationing by services" are more difficult to resolve, but even if this is the case, one cannot underestimate the complexities of "rationing by characteristics," which may involve a multitude of interconnected assessments.

With respect to "scope of coverage" cases, courts now assess claims in accordance with a general scheme that the Supreme Court articulated after its *Eldridge* decision. In *Law* v. *Canada* (1999) the Court held that a plaintiff must satisfy the following three steps in order to prove a violation of equality rights:

- The impugned law or policy must draw a distinction between groups of persons on the basis of a personal characteristic, or fail to draw such a distinction for a group already disadvantaged, in a manner that results in substantively differential treatment between the groups.

- The differential treatment must be on a ground that is enumerated in section 15 (such as sex or age) or on a ground that is analogous to an enumerated ground (such as sexual orientation).

- The differential treatment must constitute substantive discrimination, which means that it offends the plaintiff's essential human dignity.

The first two criteria are not too burdensome for plaintiffs who want an expansion of insured services. After all, the plaintiffs are patients who seek treatment for physical or mental health problems. The third criterion presents more problems, as it does generally for plaintiffs with section 15 claims. Not every distinction in health treatment between groups of patients is discriminatory; for instance, the mere fact that governments do not fund IVF or ICSI treatment for infertility is not automatically discriminatory. Patients must also convince a court that the distinction offends their dignity. The Supreme Court has said that such distinctions have "the effect of perpetuating or promoting the view that the individual is less capable or worthy of recognition or value as a human being or as a member of Canadian society, equally deserving of concern, respect, and consideration" (*Law* 1999, para. 88).

The case law to date does not provide clear guidelines to distinguish between exclusions from insured services that offend dignity and those that do not. In *Cameron*, the Nova Scotia Court of Appeal split on whether the non-insurability of IVF and ICSI impinged upon the plaintiff's essential human dignity. A majority of the Court concluded that the exclusion did violate dignity because of historical stereotyping of infertile persons, especially women, and the stigma associated with infertility. By contrast, a minority opinion ruled that the exclusion of some infertility services did not offend dignity, stating that it was "an inevitable consequence of the administration of health care" (*Cameron* 1999*a*, 682). However, the dissenting judge commented that if the government refused to fund any medical treatments for infertility, such a policy would likely offend essential human dignity (683-684).

Although the sparse case law does not permit ready generalizations, it does seem that exclusions justified by cost, risk, safety and low effectiveness will not violate human dignity. However, wholesale delisting of services might well do so. Governments will need to justify exclusions with evidence about the reasons for the exclusion; in short, they will need to prove that the exclusion is supported by sound medical evidence or other cogent reasons that are unrelated to any prejudice or stereotyping about the persons who wish to have the service. In this regard, the third criterion replicates the balancing that takes place in section 1.

In summary, section 15 does present possibilities for patients to challenge decisions about the scope of coverage. Perhaps one reason for the low number of cases in which persons seek more health services is the relative universality, accessibility and comprehensiveness of Canada's

existing Medicare system. Anyone in need of medical treatment to preserve life or health is usually entitled to receive it (Jackman 1995; Von Tigerstrom 2002). Thus it is not surprising that *Charter* cases to date have involved expensive uninsured services, such as drug prescriptions (*Brown* 1990) and fertility treatments (*Cameron* 1999, 1999*a*). Consequently, if governments change significantly the current mix of public and privately funded health care services, section 15 will become more important as a shield to protect existing coverage. In addition, however, the *Charter* may be used as a sword to obtain more insured services, such as pharmaceutical products. With escalating drug costs and increasing reliance on life-saving drugs, it is surprising that major exclusions from Medicare, such as most prescription drugs and home care, have not been subject to more *Charter* challenges.

If the courts do hold that a particular feature of the health care system violates equality rights, the government may justify the limit under section 1. For instance, in *Cameron* the majority of the Nova Scotia Court of Appeal held that the exclusion of IVF and ICSI treatments from insured services violated section 15, but was a reasonable limit under section 1. Part III discusses section 1 in more detail.

C. Section 7

Section 7 protects the right not to be deprived of life, liberty or security of the person except in accordance with the principles of fundamental justice. Its power as a tool to challenge health care policies has been limited because plaintiffs must overcome significant obstacles in proving a violation of section 7.

First, plaintiffs must show that either "liberty" or "security" encompasses health or health care services. The courts have not interpreted the rights in section 7 in a manner sufficiently broad to encompass a general right to health, or, except in exceptional circumstances, a right to access health care services. With respect to liberty, a majority of Supreme Court judges has ruled that the phrase covers only freedom from physical restraint, and not economic liberty, such as the right to engage in contractual relations (Hogg 2001, 920). With respect to security, the Court has held that it includes the right of access to health care (*R.* v. *Morgentaler* 1988), and the right to refuse medical treatment for oneself (*Rodriquez* 1993). Lower courts have ruled that security does not include the right to have health care of one's choice provided at public expense, such as public funding of drug prescriptions (*Brown* 1990*)* or enhanced public funding for nursing homes (*Ontario Nursing Home Assn.* 1990). In Nova Scotia recently, a claim under section 7 for public funding of fertility treatments was curtly dismissed by the trial court (*Cameron* 1999, para. 160), and not pursued on appeal (*Cameron* 1999*a*).

Second, even if plaintiffs can prove a deprivation of liberty or security, they must also show that the deprivation contravened the principles of fundamental justice. The Supreme Court has interpreted the phrase "principles of fundamental justice" to mean basic tenets of the legal system, such as the presumption of innocence (*Reference Re. Motor Vehicle Act* 1988). These basic tenets clearly include the rules of fair procedure, but whether they include substantive principles is more debatable. In a recent decision involving child protection hearings, the Court suggested that section 7 is restricted to situations where the infringements to liberty or security

are "a result of an individual's interaction with the justice system and its administration" (*New Brunswick (Minister of Health and Social Services)* v. *G.(J)* 1999, para. 65). With health care services, when plaintiffs challenge governmental decisions about "medically necessary services" or other funding provisions, they will find proving a violation of these principles exceedingly difficult because generally the health care system is administrative, not criminal.

One example of criminal prohibitions was the therapeutic abortion committee provisions that the Supreme Court struck down as a violation of section 7 in *R.* v. *Morgentaler* (1988). These provisions made abortion a criminal offence unless the abortion was approved by a cumbersome hospital committee structure. The unusual feature of this legislative regime was that women seeking abortions and doctors performing them were guilty of a criminal offence unless they received prior approval from a committee. A woman's access to health services and a doctor's freedom to perform the service were severely constrained by the most onerous legal sanction – criminal punishment. In this context, the Supreme Court held that a woman's right to security of the person included the right to access health care services without threat of criminal sanction, and that the convoluted and often elusive committee structure violated the principles of fundamental justice. One judge, Madame Justice Wilson, went further and held that the Criminal Code provisions also violated a woman's right to liberty.

The legal rule in *Morgentaler* was exceptional because it was situated on the overlap between the criminal law process and the health care system. A similar example is *R.* v. *Parker* (2000), where the Ontario Court of Appeal struck down the criminal prohibition against possession of marijuana for people who use the drug for medicinal purposes. However, cases in which a form of health care is subject to severe criminal penalty are rare. In an effort to overcome the stricture of criminal or quasi-criminal sanctions as a condition of section 7 claims, several commentators have argued recently that principles of fundamental justice should encompass administrative procedures, which would include a wide variety of health care policies (Karr 2000; Hartt and Monahan 2002).

Moreover, in cases where plaintiffs challenge basic tenets of the health care system, governments may be able to rely on the principles of fundamental justice to defend their decisions because these principles include other *Charter* values, such as equality and human dignity. In *Chaoulli* (2000), the trial judge ruled that the prohibition of private health insurance for services covered by Medicare, while perhaps infringing section 7 rights if the public system did not provide sufficient access to health services, did not contravene the principles of fundamental justice. The prohibition was adopted because allowing a parallel private system would impair the viability of the public system, and adversely affect the rights of the rest of the population. The judge concluded as follows: "[the prohibition is] motivated by considerations of equality and human dignity… it is clear that there is no conflict with the general values promoted by the Charter." (as quoted in Von Tigerstrom 2002, 166). The trial judge's decision was upheld by the Quebec Court of Appeal (*Chaoulli* 2002).

One underlying reason for the judicial hesitancy about broadly interpreting section 7 is the more general reluctance to include economic interests within section 7. The Supreme Court has ruled that economic rights in the corporate or commercial context do not come within section 7.

The courts are afraid of opening section 7 to a host of economic claims. Indisputably, health services are bundles of economic interests, not manna – someone must provide them, and someone must pay for them. At the same time, however, the Supreme Court has left open the question of whether section 7 could protect economic interests that are integrally connected to material well-being (*Irwin Toy* 1989, 1003-1004). Since health care qualifies as essential for well-being in the same manner as food and clothing, it remains possible to protect health care under section 7 notwithstanding its economic aspect. For instance, if people were denied access to emergency medical services because they could not pay for them, their claim of a section 7 violation could receive a sympathetic judicial hearing. Moreover, the Medicare system is extremely popular, and many citizens view it as a fundamental plank of Canadian society. This popularity may assist judges in overcoming their usual reluctance to evaluate and supervise benefits programs. The Supreme Court recently heard an appeal from a Quebec case that raises the issue of whether inadequate social assistance payments violate security of the person (*Gosselin* 1999). Its decision may foreshadow the Court's direction on analogous cases in health care.

In the near future, one can reasonably expect more *Charter* claims that address the phenomenon of waiting lists. Recently, several lawyers have argued, as in the *Chaoulli* litigation, that waiting lists impair patients' psychological health and, in some cases, threaten their lives (Karr 2000; Hartt and Monahan 2002). Further, they argue that the appropriate remedy is private health insurance that covers services now paid for by Medicare. This line of argument is attractive not only to wealthy patients who could afford private insurance, but also to those doctors and other health care providers who wish to establish private medical facilities. If successful, these arguments would have a major impact on health care costs; parallel private systems reallocate existing resources and cause an increase in the total budget, as well as raise issues of equity and access (Gray 1998, 910-913). But success for these arguments is not assured. Besides the difficulty of showing a violation of principles of fundamental justice, patients and health care providers who argue for more private insurance face an additional obstacle. Even if waiting lists violate section 7, the appropriate remedy may be more public funding or better management of waiting lists, rather than creating a system of parallel private health care by removing the ban on private insurance. For instance, since waiting lists for a specific procedure may vary greatly among a group of specialists, it might be appropriate for a court to order publication of wait times for all specialists in the province. Such an order would give patients valuable information on which to choose specialists. What is not obvious, however, is that the remedy for wait times is private insurance; this remedy would only fix the constitutional violation for wealthy people who could afford insurance, and may substantially worsen the constitutional violation of wait times for poor people, who would endure longer wait times because of a drain of medical resources to the privately funded system (Schrecker 1998, 143). As noted above, the government's egalitarian objective in prohibiting private insurance was recognized by the trial judge in *Chaoulli* (2000).

The debates about remedies for correcting wait times illustrate a major difficulty with *Charter* review of health care policies. The health care system is fiendishly complicated and simple answers to problems (such as allowing private insurance as a response to waiting lists) could wreak considerable damage to the system, and cause constitutional violations for other

groups of people. Judges are not well equipped to deal with the enormous ramifications of changing elements of the health care system. They may not obtain much help from counsel, who may have neither the expertise or interest in assisting judges in understanding fully the variables and dynamics of health care policy. For instance, it is distressing that a major article arguing for the unconstitutionality of the prohibition on private health insurance (Karr 2000) does not cite a single study from health economists or policy analysts on the causes of, and remedies for, wait times. The more recent study by Hartt and Monahan (2002) arguing that wait times violate section 7 rights, while referring briefly to several studies about wait times, fails to consider the wider consequences of judges creating a two-tier health system. The complexities of wait times and options for solving them (Lewis et al. 2000) illustrate that assessing health care policy is a quintessentially interdisciplinary undertaking. Yet judges will be wading into these thorny areas without expertise. For understandable reasons, they may adopt an attitude of extreme caution, if not deference, as they have generally done with health care cases to date (*Cameron* 1999*a*; *Chaoulli* 2000, 2002).

One last point must be made about section 7. In several cases, judges have said that violations of section 7 can only be justified under section 1 in exceptional circumstances (*Reference Re Motor Vehicle Act* 1988, 518). In practice this means that the justificatory arguments for limiting rights occur within the interpretation of the section itself (Hogg 2001, 916), defining the scope of "liberty" and "security" and the content of principles of fundamental justice. One example of this practice is the trial judgment in *Chaoulli* (2000).

D. Mobility Rights and Fundamental Principles

Of the other *Charter* provisions that affect the health care system, mobility rights deserve attention. Section 6 states that every citizen has a right to earn a livelihood in the province. Mobility rights have impaired the provinces' ability to reform their policies of physician management. British Columbia's efforts to rationalize physician services have been particularly hard hit in this regard (*Re Mia* 1985; *Wilson* 1988; *Waldman* 1999).

However, mobility rights may no longer protect doctors' freedom from regulation. The Supreme Court recently issued a major decision about section 6 in which it held that a violation of mobility rights required discrimination on the grounds of provincial residency (*Canadian Egg Marketing Agency (CEMA)* 1998). Consequently, policies that regulate doctors' practices within a particular province do not violate mobility rights, contrary to the holding in *Re Mia* and the trial judgment in *Waldman*, unless the particular scheme distinguishes between doctors on the basis of past or present residency. Most proposals for equitable distribution of doctors do not draw such distinctions, and therefore do not violate section 6. Accordingly, when the British Columbia Court of Appeal heard the appeal in *Waldman*, it applied the *CEMA* decision to hold that only one provision of the scheme violated section 6, although it refused to sever the offending provision and thus struck down the entire law (*Waldman* 1999, para. 51). Recently, when a group of doctors in New Brunswick challenged that province's rationing scheme for physician services, the New Brunswick court applied the *Canadian Egg Marketing Agency* decision to dismiss their claim (*Rombaut* 2001).

One recent case involving a hospital restructuring attracted considerable media attention, but on closer scrutiny it does not herald a new era in judicial regulation of health care policies. In *Lalonde* (2001) a group of francophone citizens challenged the decision of the Ontario Health Services Restructuring Commission to change the mandate of Hôpital Montfort, the only French-language hospital in Ontario. They argued that the decision adversely affected medical services to their official-language community. The Ontario Court of Appeal held that the Commission must respect the Constitution's fundamental organizing principles, which include protection of minorities, in its restructuring decisions. The Court quashed the decision and remitted the matter to the Minister for reconsideration in accordance with its reasons. The judgment's only novel feature was the ruling that administrative agencies must consider fundamental constitutional principles in addition to *Charter* values. It is a long established principle that governmental agencies, such as health services commissions, must respect *Charter* rights and exercise their discretion in a manner consistent with the *Charter*. The plaintiffs in *Lalonde*, however, could not rely on section 15 because of a line of cases holding that language was not an analogous ground under section 15. Hence they relied instead on the fundamental constitutional principle of protection of minorities. Given section 15's broad scope with respect to enumerated and analogous grounds, cases such as *Lalonde* where plaintiffs must resort to deeper constitutional values in challenging administrative discretion may be quite rare.

III. Section 1

Section 1 serves a dual purpose. It guarantees rights and freedoms, but also permits governments to limit those rights if the limits are reasonably justified in a free and democratic society. In the classic case of *R.* v. *Oakes* (1986), Chief Justice Dickson established the basic criteria by which to assess whether violation was a reasonable limit. The *Oakes* test is two-fold. First, the government must establish that the impugned law had an important objective. This criterion has proven easy for governments to satisfy. Indeed, there have been virtually no cases in which the test is not met (Hogg 2001, 743). In the context of health care, the government has invariably argued that its objective for a particular policy, such as not insuring particular services or rationing billing numbers, is to protect the viability of Medicare and use its resources effectively. This objective satisfies the first branch of *Oakes*.

The second branch of the *Oakes* test assesses the government's means of achieving its objective. The test is one of proportionality, with three parts. First, the means must be rationally connected to the objective. Second, the means must impair as little as possible the right or freedom; there must not be a less drastic alternative by which to achieve the ends. Third, the means must not have a disproportionately severe effect on persons to whom it applies. Generally, in almost all section 1 cases, the disputes have turned on the second part of this three-pronged test – the least drastic means (Hogg 2001, 743). The language in *Oakes* was quite stringent: the law had to impair the right as little as possible. However, later cases have softened the language considerably. Quite soon after *Oakes*, the Supreme Court recognized that governments needed a margin of appreciation in designing laws, and that courts should give some degree of deference to legislators in crafting policies. Courts now look for reasonable efforts by governments to minimize legislative infringements of *Charter* rights, rather than the least minimal interference. In short, a range of governmental policies, not merely the least drastic, will satisfy section 1.

Generally, courts are more willing to give a margin of appreciation to governments when one of several considerations is present: if the law is intended to protect a vulnerable group, such as children or poor people; if the law reconciles the interests of competing groups; if the law allocates scarce resources; or if the law rests on complex, and often competing, social science evidence (Hogg 2001, 764). Laws regulating the health care system usually possess all four of these characteristics. Accordingly, in cases involving components of the health care system, all of these considerations should come into play, resulting in a wide margin of appreciation when governments justify restrictions under section 1.

The wide margin of appreciation for governments is demonstrated in the jurisprudence. Judges understand that health care budgets are complex and controversial, involving difficult trade-offs. They have been reluctant to second-guess governments about the best way to spend health care dollars. The majority opinion in *Cameron* (1999*a*), in ruling that a section 15 violation was justified under section 1, illustrates the general judicial attitude. After reviewing the government's evidence about increases to the health care budget and federal cutbacks to cost-sharing programs, which resulted in compelling pressures on the Department of Health, it expressed considerable reluctance to find that the government's policies were unreasonable under section 1: "the evidence makes clear the complexity of the health care system and the

extremely difficult task confronting those who must allocate the resources among a vast array of competing claims.... The policy makers require latitude in balancing competing interests in the constrained financial environment. We are simply not equipped to sort out the priorities. We should not second guess them, except in clear cases of failure on their part to properly balance the Charter rights of individuals against the overall pressing objective of the scheme" (*Cameron* 1999a, 667).

With respect to predicting when the government will fail in meeting its burden under section 1, the two "scope of coverage" cases in which courts rejected the section 1 arguments are not especially helpful for drawing generalizations. In *Eldridge*, where the Supreme Court ordered the government to pay for sign language interpreters for deaf patients, it stressed that the cost was minimal. Unfortunately, it did not consider the impact of its ruling on other provinces, who might have different financial circumstances. Nor did it assess the cogency of the evidence about cost, accepting without question an intervenor's somewhat dubious estimate (Manfredi and Maoini 2002, 229). In *Auton*, the rather skimpy discussion of section 1 is unsatisfactory. The court seems to duck the issue of money, noting the cost per child, but not the total amount of the treatment. It apparently regarded the situation as identical to that in *Eldridge*, which was erroneous since the Supreme Court stressed that *Eldridge* involved access to existing services, not adding new ones. In *Auton* it seems that the most important consideration was the court's assessment that the savings created in the long run by assisting autistic children would likely offset the cost of Lovaas treatment.

The exception to this general deference is the doctors' claims that physician management schemes violated their *Charter* rights. Overall, courts have been unusually insensitive to the enormous cost ramifications of invalidating provincial rationing schemes for physician services. Although, as noted previously, the jurisprudential foundations of the doctors' victories are now shaky, the general judicial fondness for doctors' claims may carry over into new challenges brought by doctors to preserve their dominant position within the health care system. For instance, it is not unrealistic to expect challenges if a regional health authority required all doctors in its area to be paid by capitation or employment contracts, rather than permitting "fee for service" arrangements. Although section 7 does not cover the right to exercise a profession (*Reference Re Criminal Code, Ss 193 & 195.1(1)(c)* 1990, 527), past *Charter* victories by doctors would give their challenges more chance of success than analogous claims by other professions. Nevertheless, the odds of victory in challenging contractual requirements with health authorities would still be low (Flood 1999, 193).

Two clear points emerge from the case law. First, cost is indeed a consideration in section 1 balancing. In its early *Charter* jurisprudence, the Supreme Court stated rather categorically that cost could not justify infringements of rights; in other words, governments could not use money as a reason to violate *Charter* rights (*Singh* 1985, 469). If fair hearings for refugee claimants would cost hundreds of millions of dollars, as did the remedy in the *Singh* case, then the government must pay the bill. However, this rigid view about the role of costs has considerably loosened. With many rights, providing the right to one group without regard to costs may result in another group being denied its rights. Arguably, health care decision-making is a paradigmatic

example of these trade-offs. The courts may ignore the cost of providing a service if it is small (*Eldridge*) but not when it is relatively large (*Cameron*).

Second, there is a great need for cogent evidence. Even with a margin of appreciation and judicial sensitivity to the complexities of health budgeting, section 1 justifications will require evidence that the government considered alternatives to the impugned policy. This evidence could involve the cost-benefit analysis engaged in by policymakers, the medical studies that were examined, and any other relevant factors that were taken into account. If governments do not adduce evidence, their likelihood of success under section 1 is greatly diminished. In *Eldridge*, for example, the Court emphasized several times the government's failure to adduce evidence of undue strain on the health care system if the service was provided (*Eldridge* 1997, paras. 92, 94).

The obligation to produce evidence in an open court about the merits, expense, and risks of different health care options may have positive benefits for health policy. For one thing, it may deter policymakers from making decisions based on the decibel level of the group asking for a particular service at a particularly sensitive time, such as immediately before an election. Overall, it may hasten the incorporation of what has been called "evidence-based medicine" into public policy about health care.

However, there remain significant problems with judicial assessments under section 1. In the very nature of adjudication inheres one major problem: telescopic vision. As the litigation in *Eldridge* and *Auton* illustrates, in each case the court assesses only one tiny part of a very large puzzle. And, because it focuses on only one part, that part is magnified. What adjudication usually fails to consider is the opportunity cost of its orders – where else could the money be spent? Yet this is the question that necessarily preoccupies policymakers. Judicial recognition of the telescopic nature of adjudicatory methods ought to strengthen their caution about reviewing health care decisions.

IV. International Law

Canada is a signatory to international conventions about human rights. The right to health is firmly embedded in many conventions, albeit with slightly different language in each one (Toebes 1999). These conventions are binding at international law. Canada is obliged to act in accordance with these conventions, but convention rights are not directly enforceable in Canadian courts (Hogg 2001, 689). Nevertheless, they are important to a study about the *Charter* because of the long-standing principle that domestic law should be interpreted in a manner consistent with international obligations. In a recent decision, the Supreme Court emphasized that this principle includes *Charter* interpretation: "[I]nternational human rights law… is also a critical influence on the interpretation of the rights included in the *Charter*" (*Baker* 1999, para. 70).

This paper will discuss briefly one important convention, the *International Covenant on Economic, Social and Cultural Rights (ICESCR)*, as an example of the right to health in international law. Article 12 recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." It provides further that State Parties shall take steps necessary to achieve the full realization of this right, including reducing infant mortality, improving environmental and industrial hygiene, preventing and treating disease, and creating "conditions which would assure to all medical service and medical attention in the event of sickness" (*ICESCR* 1966, Art. 12(2)). This right clearly includes the right to health care, such as immunization services, essential drugs, and emergency medical treatment. But it also includes health-related issues, such as safe water, adequate sanitation, and environmental health (Toebes 1999).

International conventions require State Parties to file periodic reports describing their efforts to comply with the convention's obligations. The *ICESCR* reports are filed with the Committee on Economic, Social and Cultural Rights. With each report the Committee publishes concluding remarks, which indicate the direction of international law developments.

Canada filed its third periodic report to the Committee in 1998. In its concluding observations, the Committee did not comment negatively on health care services, except with respect to the "significant cuts to services on which people with disabilities rely" and programs for people discharged from psychiatric institutions (Committee on Economic, Social and Cultural Rights 1998, para. 36). However, it expressed concern about many aspects of Canada's social programs, including the cuts to social assistance, the restrictions on unemployment insurance, the growing problem of homelessness, and the inadequate protection of women's rights. It drew attention to the adverse consequences for poor people that flowed from the replacement of the Canada Assistance Plan with the Canada Health and Social Transfer (CHST), including the absence of national standards for social assistance programs. Furthermore, it found inexplicable the double standards in the CHST: "[The CHST] did, however, retain national standards in relation to health, thus denying provincial flexibility in one area, while insisting upon it in others [social assistance]. The delegation provided no explanation for this inconsistency" (Committee on Economic, Social, and Cultural Rights 1998, para. 19). Overall, one can conclude that Canada's Medicare program fulfills its international obligations, but its

social programs need improvement. Insofar as a right to health includes basic necessities, such as income and shelter, Canada is failing to meet its obligations.

International obligations may influence proposals to reform the existing health care system. In a number of reports, the Committee asked State Parties to report on whether disparities exist between the public and private sectors in their health care systems. Furthermore, it has noted that plans to decentralize and privatize health care services do not relieve a State Party from its obligations to promote access to health care services, especially for poor people (Toebes 1999, 105-106). Thus, if Canadian governments were to privatize health care services to a significant degree, they may run more afoul of their international obligations.

One issue in international law debates is whether social and economic rights, such as the right to health in Article 12 of the *ICESCR*, should be given the same priority as civil and political rights, such as freedom of expression. Many scholars have argued that international law should be governed by a principle of indivisibility: social and economic rights are indivisible from civil and political rights, and should have the same priority in terms of enforcement (Schabas 1999). Critics of this approach argue that social and economic rights involve different considerations, such as imposing positive obligations on governments, and should not be lumped in with civil and political rights (Richards 1999).

This debate has relevance to the question about the future impact of the *Charter* on the health care system. If the principle of indivisibility becomes more widely accepted, courts will be more willing to interpret *Charter* rights broadly to include a general right to health, and to issue *Charter* remedies for the enforcement of social rights. Insofar as judicial deference is grounded, at least in part, on acceptance of a distinction between political rights and social rights, a removal of the distinction weakens that particular argument for deference.

V. The *Charter* and Future Developments

This paper addresses the question of the impact of the *Charter* on health care costs. The case study shows that the number of successful *Charter* challenges since 1982 is not large, and the impact of these decisions, except for the doctors' challenges, has not yet been significant. Most claims have played around the edges of the current health care system, rather than attacked its foundations, and many court decisions have been sensitive to the dynamics of health care reform.

One reason that the *Charter*'s impact has not been revolutionary is the relative comprehensiveness and accessibility of the Medicare system. A number of basic principles informed the Royal Commission in the 1960s and are currently articulated in the *Canada Health Act*. In particular, the three principles of universality, accessibility, and comprehensiveness can be cast as manifestations of the *Charter* values of equality and protection of human dignity. In this respect, *Charter* rights augment the existing health care system; to state the obvious, section 15 claims about the scope of coverage do not introduce equality as a foreign concept to the health care system. However, apparent compatibility between Medicare's principles and *Charter* values does not forestall continued litigation. Since general principles do not mechanically translate into a single set of practical policies (Okma 2002, 46), agreement in principle does not erase sharp disagreement about implementation. Moreover, more litigation can be expected if governments engage in reform measures that are perceived to depart from *Charter* values, or if courts change their views about what are *Charter* values.

Several structural factors will also influence the extent of future *Charter* litigation. First, litigation is expensive. Individuals rarely have sufficient personal resources to initiate a major constitutional challenge. If individuals with complaints about inadequate health services do have money, they are more likely to use it to buy the medical services they need rather than go to court. Moreover, public funding for litigation is not available. The Court Challenges program, which provides limited funding for individuals and groups to launch legal actions, only has power to fund cases that challenge federal laws. Since health care is a matter of provincial responsibility, and provinces make most health policy decisions, most challenges to health care policies are outside the program's purview. Second, time is an important consideration. Legal actions take a long time to proceed through the judicial system, and the very nature of some health decisions means that many patients cannot effectively use the courts.

These factors, however, have less salience for providers, such as doctors, or for private providers, such as dentists and pharmaceutical companies. With less cost constraints, they may initiate *Charter* litigation as a sword to obtain favourable policy changes, or as a shield to maintain their position. For instance, litigation to strike down the ban on private health insurance uses the *Charter* as a sword to increase private health care. The hypothetical doctors' challenge to employment or capitation contracts would use the *Charter* as a shield to prevent structural changes in physician remuneration. Moreover, *Charter* actions may be initiated as a tactic to pressure governments and influence public debate, even if the likelihood of success in court is low.

Governments could forestall some litigation by using the section 33 override. For those *Charter* cases involving sections 2, and sections 7 to 15, Parliament and provincial legislatures may declare that a law operates notwithstanding those *Charter* rights and freedoms. However, the override is not often used because of the fear of negative political repercussions. Moreover, some *Charter* rights (such as section 6's mobility rights) and the Constitution's fundamental principles fall outside the override's ambit, and governments are unable to immunize themselves from constitutional challenges on these grounds. Governments will have no recourse other than section 1 to justify interference with rights, as they have done successfully with some challenges to date.

One important question involves deciding what constitutes governmental action in the health care area. Section 32 states that the *Charter* applies to Parliament, the federal government, and the legislatures and governments of each province and territory. Hypothetically, if a government decided to privatize health care entirely – whatever that might mean (Gray 1998, 908) – the *Charter* would no longer govern the health care system. However, even if this most unlikely scenario were to unfold, the *Charter* will likely not be avoided. The question of what is government action under section 32 is notoriously complex, and it may be quite possible to find sufficient government action to ground *Charter* claims, especially since wholesale privatization does not avoid Canada's obligations under international law. The very point of positive governmental obligations is to require governments to provide particular services. Insofar as *Charter* jurisprudence develops more positive obligations (and *Gosselin* may be a harbinger), privatization options might become more difficult. In any event, the private sector is regulated by statute and the common law. The *Charter* directly regulates the former, and its values regulate the latter.

In considering reforms to the health care system, governments should take *Charter* values into account. This can be done in a number of ways that not only show respect for constitutional values, but may also diminish the risk of courts striking down health care policies. These ways are not startling, but are integral to good governance in any policy area. Specifically, policies should be justified with evidence, such as economic studies about the merits and drawbacks of particular changes. In addition, reforms should be publicly justified as furthering important *Charter* values, such as equality, and decision making within the health care system should be transparent and include procedural safeguards, such as appeals from funding decisions. Space does not permit fuller consideration of implementing these methods, but they are worthy of further study. For instance, a statutory Patients' Bill of Rights may assist courts in elucidating the core requirements of rights in the health care context. More judicial education about the economics of health care systems would do no harm. The health care system is one that every Canadian uses but few know much about, including members of the legal community. If judicial review in a democracy is a dialogue between judges and legislatures, more and better information about the content of the dialogue – in this instance, health care policy – would only enrich the debate.

VI. Conclusion

There will always be *Charter* litigation seeking to enforce and expand upon constitutional rights as a means of effecting health policy. The dynamic between the *Charter* and the health care system, or to put the matter more precisely, between judges and health care officials, is an inescapable component of Canada's health care system. To date, there have only been a few successful *Charter* challenges to the health care system, and, with the exception of the British Columbia doctors' cases, their financial impact on the system has not been great. Several fundamental *Charter* values, such as equality and non-discrimination, animate the existing Medicare system. The principles in the *Canada Health Act* fulfill Canada's international obligations with respect to health services, and go a long way toward satisfying the requirements of sections 7 and 15. Courts have shown considerable sensitivity to the dynamics of Canada's health care system, recognizing the importance of accessible health care for everyone, the unbelievably complex system in place for its delivery, and the need to give governments a wide margin of appreciation. However, the number, type, and likely success of challenges depend on many factors, including the nature of reforms introduced by governments. If governments delist more services or significantly change the mix of public and private sector delivery, they can expect more *Charter* claims from individuals using the *Charter* as a shield to preserve the current system. Alternatively, if governments do not change the system, or if they change in a controversial direction, they will face challenges from people using the *Charter* as a sword to force changes in a different direction. To lessen the impact on health care costs of the inevitable *Charter* challenges, governments can explicitly take *Charter* values into account in their health care policies, and justify their decisions with the best available evidence.

Appendix I

Canadian Charter of Rights and Freedoms

Guarantee of Rights and Freedoms

Rights and freedoms in Canada

1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

Mobility Rights

Mobility of citizens

6. (1) Every citizen of Canada has the right to enter, remain in and leave Canada.

   (2) Every citizen of Canada and every person who has the status of a permanent resident of Canada has the right
   a) to move to and take up residence in any province; and
   b) to pursue the gaining of a livelihood in any province.

   (3) The rights specified in subsection (2) are subject to
   a) any laws or practices of general application in force in a province other than those that discriminate among persons primarily on the basis of province of present or previous residence; and
   b) any laws providing for reasonable residency requirements as a qualification for the receipt of publicly provided social services.

   (4) Subsections (2) and (3) do not preclude any law, program or activity that has as its object the amelioration in a province of conditions of individuals in that province who are socially or economically disadvantaged if the rate of employment in that province is below the rate of employment in Canada.

Legal Rights

Life, liberty and security of person

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Equality Rights

Equality before and under law and equal protection and benefit of law

15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

(2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Application of Charter

Application of Charter

32. (1) This Charter applies
   a) to the Parliament and government of Canada in respect of all matters within the authority of Parliament including all matters relating to the Yukon Territory and Northwest Territories; and
   b) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province.

(2) Notwithstanding subsection (1), section 15 shall not have effect until three years after this section comes into force.

Exception where express declaration

33. (1) Parliament or the legislature of a province may expressly declare in an Act of Parliament or of the legislature, as the case may be, that the Act or a provision thereof shall operate notwithstanding a provision included in section 2 or sections 7 to 15 of this Charter.

(2) An Act or a provision of an Act in respect of which a declaration made under this section is in effect shall have such operation as it would have but for the provision of this Charter referred to in the declaration.

(3) A declaration made under subsection (1) shall cease to have effect five years after it comes into force or on such earlier date as may be specified in the declaration.

(4) Parliament or the legislature of a province may re-enact a declaration made under subsection (1).

(5) Subsection (3) applies in respect of a re-enactment made under subsection (4).

Appendix II

Table of Cases

Case name and citation	Facts	Argument, right claimed	Analysis	Disposition
Patients – specific treatment				
Brown v. *British Columbia (Minister of Health)* [1990] BCJ 151 (BC SC)	AIDS patients, drug AZT was placed on Pharmacare plan, which meant that all AIDS patients except those on social assistance or in long-term facilities had to pay for part of the drug's cost.	s.15 – discrimination against AIDS patients as compared to other patients, such as cancer patients.	No violation: the reason for AIDS drugs being on a different plan than cancer drugs has to do with a difference between the drugs, not inequality as contemplated by s.15.	Plaintiffs lost.
		s.7: deprivation of right to life, liberty and security of the person.	No violation: s.7 does not contemplate economic deprivation.	
Ontario Nursing Home Assn. v. *Ontario* [1990] OJ 1280 (Ont HCJ)	Plaintiffs challenge the provision of more funding to homes for the aged than for other nursing homes.	s.7: deprivation of right to life, liberty security of the person because better care was available at homes for the aged than at other nursing homes.	No violation: no evidence that plaintiff S was not adequately cared for; s.7 does not entitle person to additional benefits that might enhance plaintiff's life, liberty or security of the person.	Plaintiffs lost.
		s.15: discrimination	no violation: type of residence (aged/nursing) not an enumerated or analogous ground	
Fernandes v. *Manitoba* [1992] MJ 279 (Man CA)	F was in hospital but wanted to live in an apartment; if he did, he would need an attendant for 16h/day; Director of Income Security refused F's request for additional allowance.	s.7: life, liberty, security of the person.	No violation: desire to live someplace in particular is not a right protected by s.7.	Plaintiff lost.
		s.15 – discrimination on the basis of disability.	No violation: no discrimination on the basis of personal characteristics or disability	
Cameron v. *Nova Scotia (Attorney General)* [1999] NSJ 297 (NS CA)	Infertile couple, wanted government to pay for fertility treatments.	s.15: infertile people have a disability, denial of payment was substantially different treatment on the basis of disability; found to be discrimination.	Violation, but justified under s.1. Best possible health care with limited financial resources requires flexibility in apportioning social benefits; the violation minimally impaired s.15 right because it denied funding for only two procedures.	Plaintiffs lost.

Irshad v. *Ontario (Minister of Health)* [2001] OJ No. 648 (Ont. CA)	Immigrants to Ontario not eligible for medicare; upon reaching a certain immigration status, had to wait 3 months.	s.15 – denial of medical coverage on the basis of residency in Ontario.	No violation: residency requirement did not offend dignity; there were alternatives to provincial medical coverage.	Plaintiffs lost.
N (DJ) [Niznik] v. *Alberta (Child Welfare Appeal Panel)* [1999] AJ 798 (Alta QB)	N's son is autistic; N received some funding for family support, and wanted funding for further therapy and training; Director, Appeal Panel refused.	s.15: discrimination.	No violation: no evidence that N was treated differently than other similarly-situated children, N received some therapy at school; special needs were of the type that School Act provided for.	Plaintiff lost. [overruled by Auton?]
Auton v. *British Columbia (Minister of Health)* [2000] BCSC 1142 (BC SC)	Parents of autistic children want government to pay for Lovaas behavioural therapy for pre-school children; government would not fund until school age because treatment was considered "education," and it was very expensive treatment.	s.15 –discrimination: primary health care need of children with autism is early behavioural intervention, a necessary treatment.	Violation: Lovaas was medical treatment; government failed to give children the treatment they needed. Violation not justified under s.1.	Plaintiffs won; court ordered government to pay for Lovaas treatment when doctor recommended it.
Martin v. *NS WCB* [2000] NSJ 353 (NS CA)	Workplace injury caused chronic pain that caused disability; WCB did not compensate except in limited circumstances; at trial plaintiffs won.	s.15: discrimination against people who suffer chronic pain.	No violation: no evidence that sufferers of chronic pain experienced historical disadvantage or stereotyping; overall purpose of compensation scheme was compensatory.	Plaintiffs lost.
Eldridge v. *British Columbia (Attorney General)* [1997] 3 SCR 624	Deaf patients wanted government to provide sign language interpretation [SLI] when they communicated with health care providers.	s.15: failure to provide SLI, where necessary for effective communication, is discrimination on the basis of disability.	Violation: discrimination because deaf patients denied equal access to health services available to everyone. Failure to provide SLI was adverse effects discrimination; decision not to fund SLI was not justified under s.1.	Plaintiffs won. Court directed governmentt to administer Medicare legislation in manner consistent with s.1; declaration suspended for 6 months.
RR v. *Alberta (Child Welfare Appeal Panel)* [2000] AJ 580 (Alta QB)	Rs had 3 children: 2 with cerebral palsy, 1 with spastic hemiplegia; wanted funding for conductive education during school year and at summer camp; Director, Appeal Panel refused; parents knew other children with CP who got funding.	s.15: these children (denied funding) with CP were treated differently from other children with CP (received funding).	No violation: children were subjected to differential treatment, but not on listed or analogous ground; differential treatment was not on the fact of disability, but personal characteristics, specific medical needs and family situation.	Plaintiff lost.

Patients – criminalized treatment				
R. v. *Morgentaler* [1988] 1 SCR 30	Doctor violated Criminal Code by performing abortions on women who had not obtained certificate from therapeutic abortion committee at an approved hospital; women also guilty of Criminal Code offences.	s.7: breach of life, liberty and security of the person, not in accordance with the principles of fundamental justice.	Violation. State interference with bodily integrity (forcing woman to carry to term; delay and subsequent risks) and state-induced psychological stress (at least in criminal law) is a breach of women's security of the person. Deprivation not in accordance with principles of fundamental justice: defence is illusory, not all hospitals qualify to have a committee; even if they do qualify, having the committee is not mandatory. "Security of the person" includes a right of access to medical treatment for a condition representing a danger to life or health, without fear of criminal sanction.	Court declared the Criminal Code provisions invalid, and of no force and effect.
Rodriquez v. *British Columbia* (1993) 107 DLR (4th) 342	Plaintiff, who suffered from terminal illness, sought declaration that Criminal Code prohibition on assisting suicide was unconstitutional.	s.7: prohibiting persons from helping plaintiff commit suicide violates plaintiff's security of the person; s.15 – violation of equality rights on the ground of physical disability.	No violation of s.7. The security interest was infringed, but the deprivation did not infringe the principles of fundamental justice. S.15 – assuming a violation, it was justified under s.1.	Plaintiff lost.
R. v. *Parker* [2000] OJ No. 2787 (Ont CA)	P had severe epileptic seizures, conventional medicine did not control condition, but marijuana did; he could not find a legal source so he grew his own; charged with criminal offences of possession and cultivation.	s.7: prohibiting P from using a necessary medication infringed right to security of the person; threat of jail engaged right to liberty.	Violation. Depriving access (via criminal sanction) to medication reasonably required for a medical condition that threatens life or health violates security of the person. Liberty violated by threat of imprisonment; liberty also includes right to make decisions of fundamental importance, including choice of medication. Deprivations violated the principles of natural justice because blanket prohibition did little or nothing to enhance state interest.	Court declared the criminal prohibition of marijuana invalid, and of no force and effect. It suspended the declaration for 12 months, and gave a personal exemption to P.

Hospital restructuring				
Lachine General Hospital v. *Quebec* (1997) 142 DLR (4th) 659 (Que.CA).	Pursuant to restructuring legislation, several hospitals in the Montreal region were ordered closed, including an English-language hospital.	s.15 – closing hospital that primarily served anglophone patients violated equality rights of patients and personnel.	No violation. No discrimination proven; difference in bilingual hospitals before and after closure was minimal.	Plaintiffs lost.
Ponteix (Town) v. *Saskatchewan* [1995] 1WWR 400 (Sk. Q.B.)	Pursuant to restructuring legislation, many local hospitals converted to health centres, with reduced emergency/overnight service. Rural coalition reached agreement with government about such service, which plaintiff alleges was breached.	s.7 and 15 – reduced availability of emergency/overnight service violated security of the person and equality rights.	No violation. Even if Charter applies, it does not require the same standard of health care for all residents, regardless of where they live.	Plaintiffs lost.
Russell v. Ontario [1998] OJ 4116 (Ont. Ct. of Justice)	Ontario Health Services Restructuring Commission ordered Hotel Dieu, a hospital run by nuns, to shut down and transfer its operations to another hospital.	s. 2(a) freedom of religion – plaintiffs, the nuns who run Hotel Dieu, cannot carry out their religious mission to minister to the sick poor.	No violation. Freedom of religion does not entitle anyone to state support for one's religion. Nothing prevents nuns from ministering to the sick poor on that site.	Plaintiffs lost.
Wellesley Central Hospital v. *Ontario* [1997] OJ 3645 (Ont. Div. Ct.).	Ontario Health Services Restructuring Commission ordered Wellesley hospital to transfer its services to another hospital, which was administered by a religious order; individual plaintiffs, who were HIV positive homosexuals, objected.	s. 2(a), s.15 – compelling gay men to receive treatment at a hospital administered by a religious order violated freedom of religion, and was discriminatory.	No violation. No evidence that gay men would be compelled to receive treatment at the hospital; no evidence of breach of other Charter rights.	Plaintiffs lost.
SGEU v. *Saskatchewan* (1997) 145 D.L.R. (4th) 300 (Sk QB); affirmed 149 DLR (4th) 190 (Sk CA).	Hospital restructuring plan would move 20% of SGEU membership to other unions, who would be bargaining agents for these employees.	s.2(d) – mandatory move of some employees to other unions violated freedom of association.	No violation; freedom of association does not include freedom to choose one's bargaining unit.	Plaintiffs lost.
Jewish Hospital of Hope v. *Quebec* (1997) 139 DLR (4th) 456 (Que.CA).	Pursuant to hospital restructuring legislation, hospital became subject to a regional board of directors.	s.2(d) – freedom of association violated by imposing a regional board of directors.	No violation. Freedom of association does not include a hospital's administrative autonomy.	Plaintiffs lost.

Pembroke Civic Hospital v. *Ontario* [1997] OJ 3142 (Ont. Ct. Gen.Div); dismissed [1997] OJ 3603 (Ont. CA).	Heath Services Restructuring Commission ordered Pembroke Civic Hospital to merge with another one, operated by the Roman Catholic Church.	s.2(a), 7 and 15 – the religious views of RC hospital would influence health care.	No violation. Charter challenge was premature. No evidence that Roman Catholic views were forced on patients, or affected treatment.	Plaintiffs lost.
Lalonde v. *Ontario (Health Services Restructuring Commission)* [2001] OJ 4767 (Ont CA)	Bilingual hospital provided service in French 24 hours a day; government (HSRC) restructured hospital and limited its services.	s.15: discrimination against the francophone community.	No violation: language was not an enumerated or analogous ground.	
		Fundamental constitutional principle of protecting minorities violated by HSRC.	HSRC must respect fundamental constitutional principles. It failed to give serious weight and consideration to the hospital's importance to the francophone community.	Plaintiffs won. Court remitted matter back to Minister (who replaced HSRC) for reconsideration taking into account fundamental constitutional principles.
Doctors/hospital employees – discrimination				
Sniders v. *Nova Scotia* (1988) 55 DLR (4th) 408 (NS CA)	Plaintiff, a member of a bargaining unit, challenged hospital's mandatory retirement policy.	s.15 – age discrimination.	Violation. Mandatory retirement is age discrimination, and cannot be justified under s.1.	Plaintiff won. Court ordered him reinstated as employee.
Stoffman v. *Vancouver General Hospital* (1990) 76 DLR (4th) 700 (SCC).	Plaintiffs had their admitting privileges terminated when they reached the age of 65, pursuant to the hospital's mandatory retirement policy.	s.15 – age discrimination.	Hospital was not covered by Charter. However, even if it was, the s.15 violation was justified under s.1.	Plaintiffs lost.
Jamorski v. *Ontario* (AG) [1988] OJ 221 (Ont CA)	Plaintiffs were graduates of Polish medical schools, and had passed Canadian exam. They could not get internship because of differential treatment for foreigners; had to pass pre-internship program, which only had 24 places.	s.15: discrimination on the basis of graduating from accredited or non-accredited schools.	No violation: was not differential treatment because grads of accredited vs. non-accredited schools are different, unreasonable to expect that grads of both would be the same; even if there was a violation, it would have been justified under s.1.	Plaintiffs lost. Appeal dismissed.

Doctors – liberty and mobility with respect to practice

Jaeger v. *Quebec* (1998) 155 DLR (4th) 599 (Que.CA)	Foreign doctors could obtain license to practice in designated geographic regions, if they stayed in the region for 4 years. Penalty for moving earlier was $50,000/year. Plaintiff doctor, who obtained licence under the program, objected to the penalty.	s.7 – requirement to stay in one place for 4 years violated liberty. s.15 – policy discriminated against foreign doctors.	No violation. Liberty does not include freedom to practice profession wherever one wishes, without financial penalty. Equality rights not violated by special program that increased opportunities for foreign doctors.	Plaintiff lost.
Kirsten v. *College of Physicians and Surgeons* [1996] SJ 462 (Sk. QB).	Plaintiff challenged agreement with College to practice in rural Saskatchewan for 5 years, in exchange for license.	s. 6 – mobility – 5-year agreement denied right to move to another province. s.7 – liberty.	Assuming that rights were violated, plaintiff waived his Charter rights.	Plaintiff lost.
Mia v. *British Columbia (Medical Services Commission)* (1985) 17 DLR (4th) 385 (BC SC)	M studied and graduated in British Columbia, but interned, did post-graduate training and practiced outside province; British Columbia would not give M a billing number.	s.6: mobility; prima facie right to move to a province for work, and to work anywhere in province. s.7: liberty includes freedom to practice a profession.	Violation: s.6 protects right to practice on a viable economic basis anywhere in province. Liberty in s.7 protects freedom of movement within a province for purpose of pursuing professional practice; breach of principles because policy was arbitrary.	Plaintiff won. Court declared that M entitled to billing number for services rendered anywhere in province.
Wilson v. *British Columbia (Medical Services Commission)* [1988] BCJ 1566 (BC CA)	Plaintiffs were 6 doctors: 4 graduated from UBC and practised outside British Columbia; 2 were educated outside British Columbia and now subject to British Columbia restrictions; legislation gave MSC power to not grant billing numbers, and, if granted, to restrict numbers to specific area or purpose (e.g., locums).	s.7: freedom to practice profession was so severely restricted that it violated liberty; "liberty" should be interpreted generously to include right to choose an occupation and where to pursue it. s.6: mobility rights infringed by geographic restrictions within province.	Violation: liberty includes right to practice medicine in British Columbia without geographic restriction. Breach of principles of fundamental justice because of procedural unfairness (vague criteria; uncontrolled discretion of MSC) and the manifest unfairness of a scheme in which doctors with restricted numbers were at the mercy of doctors with unrestricted numbers, abuse of the system. Court did not address s.6 arguments.	Plaintiffs won. Court declared that legislation invalid, and of no force and effect.

Waldman v. *British Columbia (Medical Services Commission)* [1999] BCJ 2014 (BC CA)	Plaintiffs challenged physician supply management. MSC created a new billing system: if new billers wanted to work in a place that already had enough doctors, they could only bill a maximum of 50% of the normal rate; after 5 years of practice in British Columbia the geographical restriction was lifted; preference was given to BC-educated new doctors.	s.6: mobility rights violated by geographic restrictions.	Mobility rights violated by preference to doctors who were trained in British Columbia, or who started studies in British Columbia by a certain date; the remainder of the scheme did not violate s.6	Plaintiffs won. Court refused to sever invalid provision from valid provisions, and it declared entire scheme invalid.
		s.15: discrimination on the basis of province of training or residence.	Court of Appeal did not consider s.15; trial judge had held that s.15 not violated because billing system did not discriminate on enumerated or analogous ground.	
Rombaut v. *New Brunswick (Minister of Health and Community Services)* [2001] NBJ 243 (NB CA)	Plaintiffs challenged physician resource management plan. Doctors practising in New Brunswick before the plan came in were exempted or grandfathered; New Brunswick does not have a medical school, so there is no distinction between new doctors from here or new doctors from away.	s.6: grandfathering provisions are preferential for New Brunswick practitioners	No violation: a purpose of s.6 is to protect dignity (human rights); there is a preference that would count as discrimination, but it is not on the basis of residency; even if there is a violation it is justifiable under s.1	Plaintiffs lost.
		s.15: gender discrimination because system perpetuates the gender imbalance of the status quo.	No violation: system is equally hard on men and women, it does not promote men over women.	
		s.7: right to practise with the partners they want and be paid for it.	No violation: s.7 is not concerned with economic deprivation.	
Practice regulation				
Rocket v. *Royal College of Dental Surgeons of Ontario* (1990) 71 DLR (4th) 68 (SCC).	Several dentists challenged the rule of their professional association prohibiting advertising.	s. 2(b) – freedom of expression. Ban on advertising violated dentist's expressive freedom.	Violation. Ban prohibits legitimate forms of expression, and cannot be justified under s.1.	Plaintiffs won.
Costco Wholesale Canada Ltd. v. *British Columbia* (1998) 157 DLR 725 (BC SC).	Two optometrists challenged bylaw of Board of Examiners in Optometry, which prohibited optometrists from having business associations with non-optometrists.	s. 2(d) –ban on business associations violated freedom of association.	Violation. Freedom of association includes economic associations. Ban not justified under s.1. Absolute ban not proportionate to objective of maintaining high standards of professionalism.	Plaintiffs won.

Medicare structure *Chaoulli* c. *Québec (Procureur Général)* [2002] JQ 759 (Que.CA).	Plaintiffs challenged Quebec law that prohibited private health insurance for health services covered by Medicare.	s.7 –limits on access to the private insurance violates right of security; health care is an important personal decision, and therefore its curtailment infringes liberty right.	No violation. s.7 does not include economic rights. Even if s.7 applies, no violation of principles of fundamental justice. Prohibition aims to safeguard public system of protection of health.	Plaintiffs lost.

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